Name: _____ **Date of Birth:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell #: _____ **Home #:** _____ Text Message Reminders **YES / NO**

SS#: _____ **Gender:** _____ **Email:** _____

Please Circle Answers

Language: English / Spanish / Polish / Japanese / Sign Language / Other
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown or Not Reported
Martial Status: Married / Single / Divorced / Widowed / Legally Separated

Primary Care Physician: _____ **Location:** _____
Eyecare Provider: _____ **Location:** _____

Emergency Contact:
Name: _____ Phone #: _____ Relationship: _____

Insurance:
Primary:_____ Member ID: _____
Secondary: _____ Member ID: _____
Tertiary: _____ Member ID: _____

Eye History: Please circle all that apply.

- Glaucoma
- Macular Degeneration
- Diabetic Retinopathy
- Injuries to the eye
- Eye Lasers
- Eye Injections
- Dry Eye
- Floaters
- Lazy Eye
- Crossing Eyes
- Eyelid Turning in or out
- Retinal Detachment
- Neurological Problems (Nerve Palsy/ Bell's Palsy)
- Eyelid Surgeries

Eye Surgeries (Circle): Cataracts - Glaucoma - Eyelid - LASIK - RK

Dates of Eye Surgeries: _____

Eye Drops / Eye Medications: _____

Name: _____ **Date of Birth:** _____ **Date:** _____

Medical History: Please check all that apply

- Arthritis / Other Arthritis _____
- Cancer (type): _____
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Diabetes
- HIV
- Hepatitis A/B/C
- Sjogren's Disease
- Stroke
- Thyroid Disease
- Grave's Disease
- Heart Attack
- Multiple Sclerosis

Other Medical History: _____

Family History: (Circle): Unknown/Adopted - Blindness - Color Blindness - Cancer (type) _____ Corneal Disease - Cross Eyed (strabismus) - Lazy Eye (amblyopia) - Macular Degeneration - Retinal Disease Glaucoma - Other _____

Surgical History:

_____

_____

_____

Social History: Smoking/Tobacco/Vaping: Yes / No / Former- If yes, how many packs? _____

Alcohol: Yes / No If yes circle how often? Occasional / 1-2 Daily / 3-4 Daily / Other:_____

_____

Caffeine: Yes / No

Fall Risk Assessment: No falls in the current/last year / 1 or more falls in the current/last year

Name: _____ **Date of Birth:** _____ **Date:** _____

Medications:

_____

_____

_____

Pharmacy Name: _____ **Location:** _____

_____

Allergies/Reactions:

_____

_____

Allergy/ Immunology:
- Autoimmune
- Seasonal Allergies
- Other: _____

Cardiovascular: Heart
- Chest Discomfort
- Irregular Heartbeat
- Chest Pain
- Shortness of Breath
- Other: _____

Genitourinary:
- Bladder Trouble
- Kidney Failure
- Kidney Problems
- Other:_____

Hematology / Oncology
- Bleeding
- Easy Bruising
- Other: _____

Musculoskeletal: Bones/Muscle
- Back Pain
- Joint Swelling
- Muscle Weakness
- Arthritis
- Other: _____

Psychiatric: Mental Health
- Depression
- Anxiety Disorder
- Bipolar
- Schizophrenic
- ADHD
- Other: _____

HENT: Ears, Nose, Throat
- Hearing Loss
- Sinus Problems
- Sore Throat
- Other: _____

Neurological: Nervous System
- Poor Balance
- Dizziness
- Headaches
- Memory Loss
- Seizures / Convulsions
- Other: _____

Integumentary: Skin
- Rash
- Severe Itching
- Other: _____